AIG

AIG Benefit Solutions

Underwritten by

American General Life Insurance Company*

Houston, Texas

The United States Life Insurance Company In the City of New York

New York, New York

National Union Fire Insurance Company of Pittsburgh, PA

New York, New York

*This company does not solicit business in New York

Critical Illness Benefit Claim Form

CLAIMS SUBMISSION: Phone: 800-348-6908 Fax: 888-446-3205 Email: med_claims@aig.com

1. Please complete the Insured/Claimant's Information section and attach a copy of the claimant's birth certificate.
2. Please read the Fraud Statement and sign in the space provided.
3. Please read the HIPAA Authorization section and sign in the space provided. The authorization will help us obtain any additional information needed to complete our processing of your claim. Failure to sign the authorization may delay the processing of your claim.
4. Have your attending physician complete the Attending Physician Statement section of the form that corresponds to the specific critical illness for which the claim is being made. If you are filing for cancer under the critical illness plan, please attach the pathology report that confirms the diagnosis.
5. Mail your claim to: American General Life Insurance Company
   P. O. Box 1581, MSN 2-E
   Neptune, NJ 07754-1581
   Phone: (800) 348-6908

INSURED/CLAIMANT'S INFORMATION							
Name of Insured (first, middle initial, last) (Please Print)				Social Security Number		Policy Number L4R529	
Insured's Address, Street & No.				City		State	Zip
Phone No.	Date of Birth	Male ☐	Female ☐	Employed At City of Round Rock		Occupation	
Claimant's Name for whom claim is being made (first, middle initial, last)				Claimant's Relationship to Insured		Single ☐ Married ☐	
Claimant's Address, Street & No.				City	State	Zip	
Claimant's Sex	Claimant's Date of Birth	If over age 19 and attending school or college, give name and address of school					

CRITICAL ILLNESS INFORMATION			
What is the specific critical illness for which the claim is being made	When was the critical illness first diagnosed	Have you ever had the same or a similar condition: ☐ Yes	☐ No
List the name, address, and telephone number for all attending physicians for the critical illness (please attach a separate list if additional space is needed)			
If the critical illness required hospitalization, provide the name and address of the treating facility (please attach a separate list if additional space is needed)			

Insured's signature:	Date:	Claimant's signature:	Date:

AIG

AIG Benefit Solutions

Underwritten by

American General Life Insurance Company*

Houston, Texas

The United States Life Insurance Company In the City of New York

New York, New York

National Union Fire Insurance Company of Pittsburgh, PA

New York, New York

*This company does not solicit business in New York

Fraud Statement

FOR RESIDENTS OF ALL STATES OTHER THAN THOSE LISTED BELOW:

Any person who knowingly, and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE OF INSURED _____ DATE _____

AIG

AIG Benefit Solutions

Underwritten by

American General Life Insurance Company*

Houston, Texas

The United States Life Insurance Company In the City of New York

New York, New York

National Union Fire Insurance Company of Pittsburgh, PA

New York, New York

*This company does not solicit business in New York

Physician's Statement - Critical Illness

INSTRUCTIONS

Please complete pages 1 and 2 of the Attending Physician Statement specific to your patient's critical illness and fully complete the Signature section.

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name	Date of Birth	Date of Death (if applicable)

When did signs and/or symptoms first appear?	Has the patient ever received medical advice or treatment for this or a similar condition? ☐ Yes, when _____ ☐ No	Diagnosis (including complications)

CANCER/CARCINOMA IN SITU

Date of diagnosis (the date the pathological specimen(s) were obtained on which cancer or carcinoma in situ were diagnosed)	Stage	Was the cancer/carcinoma in situ ☐ Pathologically diagnosed, or ☐ Clinically diagnosed

If the cancer/carcinoma in situ was pathologically diagnosed, attach a copy of the pathology report. If the cancer/carcinoma in situ was clinically diagnosed, please provide the reason(s) that pathological diagnosis was not obtained and attach medical evidence that supports the diagnosis of cancer.

MYOCARDIAL INFARCTION (HEART ATTACK)

Does the patient's condition meet all of the following criteria:

1.	Are new and serial electrocardiographic (EKG) findings consistent with myocardial infarction? Attach a copy of the EKG's and reports.	☐ Yes	☐ No
2.	Were cardiac enzymes elevated above generally accepted laboratory levels of normal for creatine physphokinase (CPK), a CPK-MB measurement must be used? Attach a copy of the lab report.	☐ Yes	☐ No
3.	Did diagnostic studies confirm a myocardial infarction and the occlusion of one or more coronary arteries? Attach copies of any applicable reports.	☐ Yes	☐ No
4.	Did the patient have chest pain consistent with myocardial infarction?	☐ Yes	☐ No

Date of diagnosis (the date the patient met all of the above criteria for myocardial infarction)

CORONARY ARTERY BYPASS SURGERY

Did the patient undergo open heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts? If so, attach a copy of the operative report. ☐ Yes ☐ No

What condition caused the need for coronary artery bypass surgery?	When was the patient first treated for signs or symptoms of this condition?

MAJOR ORGAN TRANSPLANT

Did the patient undergo surgery to receive human bone marrow, heart, lung, liver or pancreas? If so, attach a copy of bypass grafts? If so, attach a copy of the operative report. ☐ Yes ☐ No

What condition caused the need for the organ transplant?	When was the patient first treated for signs or symptoms of this condition?

STROKE

Did the patient have a stroke, meaning a cerebrovascular incident caused by infarction of brain tissue, cerebral hemorrhage, thrombosis, or embolization from an extra-cranial source lasting more than 24 hours; and producing measurable neurological deficit persisting for at least 30 days following the occurrence of the stroke. Stroke does not include transient ischemic attacks (TIAs), vertebro-basilar insufficiency, or incidental findings on imaging studies. ☐ Yes ☐ No

Date of diagnosis (the date a stroke occurred based on documented neurological deficits and neuroimaging studies?

AIG

AIG Benefit Solutions

Underwritten by

American General Life Insurance Company*

Houston, Texas

The United States Life Insurance Company In the City of New York

New York, New York

National Union Fire Insurance Company of Pittsburgh, PA

New York, New York

*This company does not solicit business in New York

Physician's Statement - Critical Illness

ATTENDING PHYSICIAN'S STATEMENT (continued)

RENAL FAILURE

Does the patient have end stage renal failure presenting as chronic, irreversible failure of at least one of the kidneys to function?	☐ Yes	☐ No
Does the patient's kidney failure necessitate regular renal dialysis, hemo-dialysis or peritoneal dialysis (at least weekly) or which results in kidney transplantation?	☐ Yes	☐ No

Date of diagnosis (the date a doctor or physician recommends that the patient begin renal dialysis)

What is the cause for the patient's renal disease?	When was the patient first treated for signs or symptoms of this condition?

PARALYSIS

Under the provisions of this policy, Paralysis/Paralyzed means Quadriplegia, Paraplegia or Hemiplegia that is expected to last for a continuous period of 12 months or more from the earlier of the date of the accident causing Paralysis or the date of the diagnosis of the sickness.

"Quadriplegia" means the complete and irreversible Paralysis of both upper and lower limbs.
"Paraplegia" means the complete and irreversible Paralysis of both lower limbs.
"Hemiplegia" means the complete and irreversible Paralysis of the upper and lower limbs of the same side of the body.
"Limb" means entire arm or entire leg.

Is the patient paralyzed as the result of a sickness or injury?	☐ Yes	☐ No
Is the paralysis the result of a sickness or an injury?	☐ Sickness	☐ Injury

What sickness or injury caused the paralysis?	What was the date of the accident, which caused the injury or the date the sickness was diagnosed?

Did the patient's sickness or injury result in Quadriplegia?	☐ Yes	☐ No
Did the patient's sickness or injury result in Paraplegia?	☐ Yes	☐ No
Did the patient's sickness or injury result in Hemiplegia?	☐ Yes	☐ No

LOSS OF SIGHT, SPEECH OR HEARING

Does the patient have irreversible loss of sight in both eyes?	☐ Yes	☐ No

What is the patient's corrective visual acuity in both eyes?	What is the patient's field of vision in both eyes?

Date of diagnosis?

Does the patient have irreversible loss of speech?	☐ Yes	☐ No

What condition caused the loss of speech? Attach a copy of the documented evidence of the illness for the continuous 12-month period prior to diagnosis.	When was the patient first treated for signs or symptoms of this condition?

Does the patient have irreversible loss of hearing as established by an audiometric and auditory threshold test?	☐ Yes	☐ No

What is the patient's auditory threshold while utilizing a hearing aid?	Date of diagnosis?

ATTENDING PHYSICIAN'S SIGNATURE

I hereby certify that the above described information is based upon reasonable medical probability, and is true and correct to the best of my knowledge and belief.

Name (attending physician) please print	Degree	Telephone number	
Address	City	State	Zip
Signature	Date	Federal Tax ID #	

AIG

AIG Benefit Solutions

Underwritten by

American General Life Insurance Company*

Houston, Texas

The United States Life Insurance Company In the City of New York

New York, New York

National Union Fire Insurance Company of Pittsburgh, PA

New York, New York

*This company does not solicit business in New York

HIPAA

Health Insurance Portability and Accountability Act ("HIPAA")

Authorization to Obtain and Disclose Information

Claimant's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and National Union Fire Insurance Company of Pittsburgh, PA and their authorized representatives, as well as other agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other American General Life company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the American General Life Insurance Company Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and National Union Fire Insurance Company of Pittsburgh, PA . I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Signature of Claimant or Claimant's Personal Representative Date

_____

Description of Authority of Personal Representative (if applicable)